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ABSTRACT

The therapist-client relationship is considered one of the most important aspects of the process of individual psychotherapy. The therapeutic or working alliance is one aspect of the therapist-client relationship that is hypothesized to be especially important. Utilizing the Vanderbilt Therapeutic Alliance Scale, this study compared audiotaped therapy segments from a sample of time-limited therapy clients with a similar group of time-unlimited or open-ended clients. Subjects were predominantly female graduate and undergraduate student clients who were randomly assigned to either a 5-session time-limited therapy condition (N=16) or an open-ended therapy condition (N=15). Results indicated that the setting of time limits in individual psychotherapy did not appear to enhance the therapeutic alliance. Therapists and clients in time-limited therapy did not develop roles, attachments and shared responsibilities significantly better than their counterparts in time-unlimited therapy. (ABL)

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Effects Of Time-Limited Counseling On The Therapeutic Alliance

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Introduction

The therapist-client relationship is said by many to be one of the most important aspects of the process of individual psychotherapy (e.g., Frank, 1973; Gelso & Carter, 1985; Hartley & Strupp, 1983; Orlinsky & Howard, 1978; Rogers, 1957). The therapeutic or working alliance is one aspect of the therapist-client relationship that is hypothesized to be especially important. Overall, the therapeutic or working alliance is the collaborative interaction between the therapist and client geared toward alleviating the client's problems. Bordin (1979) defines the alliance as being composed of three features: (1) an agreement on goals between the therapist and the client, (2) an assignment or specification of tasks to the therapist and client, and (3) the development of bonds and attachments between therapist and client. Some researchers (e.g., Hartley & Strupp, 1983; Luborsky, 1976) have operationalized this construct and developed measures based upon ratings of therapy process. Such research has shown that high scores on these measures taken early in therapy are indicative of positive therapeutic outcome.

Advocates of time-limited therapy contend that the setting of time-limits at the outset of therapy fosters the therapeutic alliance, which in turn is responsible for beneficial outcome (Mann, 1973). Some studies have indicated that the setting of time-limits in individual therapy results in positive therapeutic outcome. Moreover, several studies have shown time-limited therapy to be superior to time-unlimited therapy (Johnson & Gelso, 1980). While there have been numerous process and outcome studies examining time-limited therapy, to date there has been no investigation of the hypothesis that time-limited therapy facilitates the formation of the therapeutic alliance relative to time-unlimited therapy. This study is an attempt to fill this current void in the literature.

Utilizing the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983), the present

study compares audiotaped therapy segments from a sample of time-limited therapy clients with a similar group of time-unlimited or open-ended therapy clients .

Method

Overview

The current investigation utilized previously collected audiotapes from the Ohio University Counseling and Psychological Services Center. The sample was comprised of predominantly female graduate and undergraduate student clients who were randomly assigned to either a 5 session time-limited therapy condition (n= 16) or an open-ended therapy condition (n=15). Two independent judges, blind to condition, used the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983) to rate 15-minute composite segments from the second and third sessions in both conditions.

Clients Students seeking individual counseling at the Center were asked to participate in the original process study of time-limited therapy vs. open-ended therapy (see Stedman, 1984 for a complete description). Students were excluded in accordance with standard exclusion criteria for time-limited therapy (e.g., those unable to define a focus for treatment, those who exhibited a significant thought disorder, those who exhibited significant suicidal ideation).

Therapists Four experienced therapists, two male and two female, at the Ohio University Counseling and Psychological Services Center voluntarily served as the therapists in this project. Two of the therapists active in the project held Ph.D. degrees in Counseling, and the other two held Ph.D.'s in Clinical Psychology. The overall theoretical orientation of the therapists is best described as ecletic and client-centered. The four therapists ranged in years of post-doctoral experience from three to 15 years, with a mean of 8 years experience. None of the therapists were experienced in setting time-limits in the first hour of therapy, as required in this study. Therapists saw an approximately equal number of clients in each condition.

Experimental Conditions

Time-Limited Therapy. Time-limited therapy was defined as a condition in which therapists and clients agreed to meet for five sessions. (Because the mean number of session at the therapy center is five, the length seemed suitable for this project.) Therapist were instructed to implement the five session limit near the end of the first session. The limits were to be imposed by informing clients that the nature of their problem lent itself well to being solved within a five-session framework, and therapists thus asked clients to agree to meet for four more sessions. Beyond the setting of time-limits in the first session, therapists in this condition were not instructed to change their therapy style.

Open-Ended Therapy. As in the time-limited condition, no instructions were given concerning changing their therapy style. The only requirement of therapists in this condition was that they did not set any specific time-limits with clients.

Dependent Variable

The measure used in this study was the Vanderbilt Therapeutic Alliance Scale (Hartley, 1978; Hartley & Strupp, 1983). This is a 44-item scale composed of a therapist subscale, a patient subscale and an interaction subscale, designed to assess the quality of the working relationship between therapist and client. This scale proved useful in a previous study that examined: 1) The relationship between the strength of the therapeutic alliance and outcome in brief individual psychotherapy, and 2) the strength and pattern of development of the therapeutic alliance across time with different outcome groups.

Raters

Two female doctoral candidates in clinical psychology served as raters for the study. Both raters were aware of the nature of the study, but neither was cognizant of the specific hypotheses to be tested. (A Chi-Square analysis revealed that raters were blind to experimental conditions.) Raters

underwent a lengthy training procedure that entailed discussion of each item on the scale and performed sample ratings until they reached a criterion of one-step agreement on 80% of the items. (A total of nine 15 minute audiotaped segments not used in the study were used for training purposes and the agreement criterion was reached rating the fourth segment.)

Results

Interrater reliability.

Reliability of the ratings between the two judges was assessed in several ways. First, Pearson product-moment correlation coefficients for all the items across each subscale was obtained. The correlations for each session were computed separately. These correlations ranged from .56 to .77 with a median of .73. The Pearson product-moment correlation across all items across subscales for session 2 was .72, and for session 3 was .71. Another measure of reliability was the extent to which raters agreed and disagreed on individual items. The two raters had an overall exact agreement rate of 53% on all of the items, while they were discrepant by one-step on an additional 42%. Thus, raters had a within one-step agreement rate of 95%, comparable to the rate of 92% reported in the one previous study to use this scale (Hartley & Strupp, 1983). This measure of agreement, combined with the correlations described above, speaks to the overall good reliability of the ratings. Consequently, both sets of ratings were summed and then used in the statistial analyses.

Group Analyses

Multivariate analyses of variance. A two factor (condition X session) repeated measures multivariate analysis of variance (MANOVA) was performed in order to test the hypothesis that the imposing of time-limits enhances the therapeutic alliance in individual psychotherapy. The three subscale totals were the dependent variables. The overall multivariate F-test for condition was nonsignificant ($F(3,27)=.17$, $p=.92$). Nonsignificant univariate F values were obtained for the three

subscales: the therapist subscale ($F(1,29)=.50$, $p=.48$), the patient subscale ($F(1,29)=.29$, $p=.59$), and the interaction subscale ($F(1,29)=.43$, $p=.52$).

The overall multivariate F-test for session was nonsignificant ($F(3,27)=.49$, $p=.69$). Again, nonsignificant univariate F values were obtained for each of the subscales: the therapist subscale ($F(1,29)=.20$, $p=.66$), the patient subscale ($F(1,29)=0$, $p=.98$), and the interaction subscale ($F(1,29)=.93$, $p=.34$).

The condition X session interaction was also nonsignificant (multivariate $F(3,27)=.30$, $p=.82$). Univariate F values were as follows: the therapist subscale $F(1,29)=.06$, $p=.81$, n.s., the patient subscale $F(1,29)=.38$, $p=.54$, n.s., and the interaction subscale $F(1,29)=.93$, $p=.34$, n.s.

Discriminant function analyses. Discriminant function analyses were performed in order to check for patterns of differences between groups. Total scores for the therapist, patient, and interaction subscales were used as the dependent measures.

Analysis of session 2 yielded a nonsignificant discriminant function; only 48% of the cases were able to be classified correctly on the basis of the subscale scores (Wilk's Lambda= 0.97, $p=.87$). Similarly, analysis of session 3 yielded a nonsignificant discriminant function; group membership was able to be accurately predicted only 55% of the time (Wilk's Lambda= 0.97, $p=.83$).

Thus, the results of the present study show no differences in terms of the therapeutic alliance between therapy dyads which had a time limitation as compared to those which had no time-limit imposed.

Discussion

In theory, time-limits encourage client optimism and create more structure for the ensuing therapy (Koss, Butcher, & Strupp,1986) and both therapist and patient are believed to be forced into taking more active roles (Mann, 1973). Because therapists and patients are thought to work better

together while under time constraints, the therapeutic alliance is said to be enhanced. Contrary to this general hypothesis, the results of the present study indicate that the setting of time-limits in individual psychotherapy does not appear to enhance the therapeutic alliance.

Previously, Stedman (1984) examined the same two groups of therapy dyads as those used in the present study and found that therapists in the time-limited condition on the whole were more directive, interpretive, and had more goal-oriented behavior. Stedman speculated that decreased levels of participation and initiative noted in clients were a reaction to the therapists conducting time-limited therapy, rather than a reaction to the time-limits themselves. While Stedman's research has shown that the imposition of time-limits in therapy affected the therapeutic process, most notably therapist behavior, the current study suggests the collaborative effort between therapist and clients (i.e., the therapeutic alliance) was not affected as a function of time-limits; therapists and clients did not develop roles, attachments and shared responsibilities significantly better than their counterparts in time-unlimited therapy.

The imposition of time-limits, and consequently an increased therapeutic alliance, is an integral part of Mann's (1973, 1982) conceptualization of why time-limited therapy is successful with many clients. While it is clear that time-limited therapy is efficacious (Johnson & Gelso, 1980) the present study suggests beneficial outcomes of time-limited therapy clients cannot be attributed to a relatively enhanced or "stronger" therapeutic alliance due solely to the imposition of time-limits. It is important to note that the current study assessed the use of explicit time-limits in therapy, independent of any other time-limited therapy techniques. It is possible to speculate that time-limited therapy as described by Mann (1973, 1982) and others (e.g., Davanloo, 1980; Malan, 1976; Sifneos, 1972, 1979) does indeed result in an increased therapeutic alliance relative to open-ended therapies. However, if this does occur, the current study suggests it is for reasons other than a direct result from

the imposition of time-limits.

It is unclear how closely the therapists in the current study mimicked the ideals of Mann, Sifneos, Malan, and Davanloo. In fact, therapists were not attempting to conduct brief psychodynamically-oriented therapy as theorized by Mann and others, but are best described as eclectic with client-centered and existential influences. One possibility is that therapists involved in the current study acted in accordance with some of the basic tenets of time-limited therapy (e.g., increased activity), but did not carry out a brief, focused, anxiety-arousing dynamically-oriented therapy emphasizing transference interpretations and confronting resistance, as espoused by Mann et al. It is interesting to note, however, that clients in the time-limited therapy condition were found to have higher levels of anxiety immediately following the first session of therapy, which was when the time-limit was implemented (Molteni,1984). Consistent with theory, the time-limited condition appears to have increased initial anxiety in these clients. However, it remains unclear whether these clients continued to remain in an anxious state, as theory would predict, as these measurements were not obtained after subsequent sessions.

It is important to remember that while therapists in this study were inexperienced in setting time-limits, they were used to working with clients while under some time constraints, given the ten-week quarter system on which the university operates and the relatively transient student population. In fact, the *five* -session limit implemented in the present study was derived from the average number of sessions at the counseling center. Thus, while therapists reacted to the imposition of the time-limits with increased activity and directiveness, the quality of the collaborative relationship remained unaffected. It appears that therapists at the counseling center are accustomed to conducting therapy within five sessions for the majority of clients seen, and may in fact impose an implicit time-limit on their work. These therapists may have what some have called a "time-limited attitude"

(Binder, Henry, & Strupp, 1987).

Given this framework, the present study may be construed more accurately as comparing the effect of explicit time-limits with implicit time-limits on the therapeutic alliance. In terms of the collaborative working relationship, the imposition of an explicit time-limit did not seem to make a difference in comparison to the implicit time-limits under which the therapists in this study are accustomed to working. Thus, therapists in this study were already "brief therapists" in a sense with or without the explicit time-limit imposition. The salient, explicitly-imposed time-limit forced therapists to be more active, but did not increase the collaborative work of therapists and patients.

The brief, psychodynamically-oriented therapists (e.g., Mann, Sifneos) detail specific procedures that they assert lead to a strong therapeutic alliance. More research is needed to see if the various techniques supposedly employed by these therapists, do in fact, lead to a strong therapeutic alliance. In the current study, it is likely that therapists did not continually employ techniques espoused by Mann et al. However, therapists in this study were used to developing and utilizing the therapeutic relationship within some time constraints and the setting of an explicit time-limit did not affect the therapeutic alliance as measured by the Vanderbilt Therapeutic Alliance Scale.

It is noteworthy, that while the therapeutic alliance did not increase in the time-limited therapy condition, neither did it suffer. This has positive implications for the use of time-limited forms of therapy: a concept shown to be important for therapeutic outcome in previous research is not adversely affected by briefer, time-limited forms of therapy.

It is only in recent years that attempts have been made to measure the therapeutic alliance. Unfortunately, there is no therapeutic alliance scale that has extensive reliability and validity data. The alliance measure used in the current investigation (Vanderbilt Therapeutic Alliance Scale; Hartley & Strupp, 1983) proved useful in a previous investigation and has, relatively speaking, a respectable

amount of reliability and validity data. Further research and refinement of the therapeutic alliance scales will enable the conclusions suggested by the current study to be more thoroughly examined.

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